PATIENT REGISTRATION FORM

James M. McKee, DPM - Podiatry Group of Annapolis, PA
Podiatry Group of Annapolis Ambulatory Surgical Center, LLC
139 Old Solomons Island Road, Suite C, Annapolis, MD 21401
Phone 410-224-4448 – Fax 443-949-9539
www.podiatrygroup.us

Patient Information

Full First Name:____________________ MI:___ Last Name:____________________

Address:____

Home #:___________________________ Work#:______________________________

Cell#:___________________E-mail address:___________________________________

Please circle the number where you would you like to receive lab results and/or appt. reminder calls? Do we have permission to leave a message concerning medical information on that number? Yes:______________ No:_______________

Date of Birth:__________________ Age:___________ Sex:________Military:________

Social Security Number:_____________________Marital Status:__________________

Occupation:__________________Employer:__________________________________

Employer's Address:____

Spouse's Name (or Parent/Guardian):_______________________________________

Spouse's (or Parent/Guardian) Date of Birth:__________________________________

Spouse's (or Parent/Guardian) Social Security Number:_________________________

Spouse's (or Parent/Guardian) Employer, Address and Work#___________________

____

Primary Care Physician and Phone#____

Referring Physician and Phone#____

How did you hear about our office? Please circle:

Physician * Friend * Co-Worker * Family * Yellow Pages * Web Site * Google

Please list who or where:____

BILLING AND INSURANCE INFORMATION

We will send your bill to your home address unless you provide us with a different

address listed here:____

PRIMARY INSURANCE

(Please provide card for copying along with photo ID)

Insurance Name:____

If necessary, did you bring your referral?: Yes/No/NA

If a referral is necessary for treatment today and you do not have one the doctor is not allowed to treat you under the terms of your insurance contract.

Insurance Phone # for eligibility:______________________ Claim Address:___________

____

Policy /Member ID:_____________________Group/Account#:_______________________

If you are not the primary insured then please fill out the following:

Primary Insured's Full Name:__________________________Date of Birth:____________

Primary Insured's home address:____

Primary Insured's Social Security Number:_______________________ Sex:_________

Employer's Name:_________________________________ Phone:__________________

Employer's Address:____

Patient's relationship to Primary Insured:_______________________________________

Signature:________________________________

Date:_________________________

SECONDARY INSURANCE
(ONLY if patient has Medicare primary/secondary)

Insurance Name:____

If necessary, did you bring your referral?: Yes/No/NA
If a referral is necessary for treatment today and you do not have one the doctor is not allowed to treat you under the terms of your insurance contract.

I
Insurance Phone # for eligibility:_____________________ Claim Address:__________

____

Policy /Member ID:___________________Group/Account#:_______________________

If you are not the primary insured then please fill out the following:

Primary Insured's Full Name:_________________________Date of Birth:___________

Primary Insured's home address:____

Primary Insured's Social Security Number:______________________ Sex:_________

Employer's Name:________________________________ Phone:_________________

Employer's Address:____

Patient's Relationship to Primary Insured:_____________________________________

RELEASE OF MEDICAL INFORMATION – ASSIGNMENT OF BENEFITS

I authorize James M. McKee, DPM, Podiatry Group of Annapolis, PA, and Podiatry Group of Annapolis Ambulatory Surgical Center, LLC (collectively "Podiatry Group") to apply for benefits on my behalf for services rendered by Podiatry Group. I request payment from my insurance company be made directly to Podiatry Group. I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

It is understood and agreed that I will reimburse Podiatry Group for the cost of any and all co-payments, co-insurance, deductibles, non-covered services, excluded services, denials due to pre-existing conditions, denials due to elective services and any other costs not reimbursed in full by my insurance carrier upon receipt of an account statement.

______________________________________ ________________________

Patient/Subscriber and/or Beneficiary Date

MEDICAL HISTORY
REASON FOR TODAY'S VISIT/HISTORY OF PRESENT ILLNESS

What is the reason for your visit today? (Chief Complaint)________________________
____

Where is the problem and/or pain located?______________________________________
____

Describe how it feels? Is it burning, throbbing, sharp, dull, aching, numb or other?____
____

How long have you had this problem and/or pain?_______________________________
____

Does the problem and/or pain occur at a specific time?___________________________
____

Where were you or what were you doing when this problem and/or pain began?
____

What makes the problem and/or pain better or worse?____________________________
____

Have you tried to treat the problem and/or pain yourself? If yes, how?____________
____

MEDICATIONS

Please list (or attach) your current medications and dosages (including any vitamins and supplements):

MEDICATION	REASON/USED FOR

SIGNATURE:________________________________

ALLERGIES and REACTIONS

Please circle and note what allergic or adverse reactions to the following:

Adhesive /Tape:___________ Anticoagulants:___________ Aspirin:___________
Codeine:__________________ Demerol:_________________ Iodine:___________
Local Anesthetics:_________ Novocain:________________ Penicillin:_________
Seafood:__________________ Sulfa:____________________ Latex:____________
Other:____________________
No Known Allergies

Name/location/phone number of pharmacy:____________________________________
____
(for submission of Electronic Prescription)

FAMILY MEDICAL HISTORY

If there is a Family History of any of the following disorders, please circle:

TB, Kidney, Hypertension, Heart, Spine, Allergies, Cancer, Gout, Arthritis, Migraines, Diabetes, Epilepsy, Depression, Other (please explain)____________________________

SOCIAL HISTORY

Do you smoke?________ If yes, number of years?______ How many per day?________
Do you drink alcohol? Yes/No How many drinks per day/week?__________________
Do you use recreational drugs now or in the past? Yes/No If yes, please describe:
____
Caffeine: Quantity:________________
Are you pregnant?________________

Height_____________________________Weight___________________________________

PAST SURGICAL AND HOSPITALIZATION HISTORY

Please list all surgeries/serious illnesses/hospitalizations:
____
____
____

IMMUNIZATIONS

Please circle those immunizations that you have received and are up to date:

Measles, Mumps, Polio, Tetanus, Typhoid, TB, Pneumonia, Flu, Other_______________
____

SIGNATURE:_______________________________

REVIEW OF SYSTEMS

NEUROLOGICAL- Stroke, Paralysis, Peripheral Neuropathy, Multiple Sclerosis, Shingles, Lyme's Disease, Fibromyalgia, Reflex Symptomatic Dystrophy, Charcot Marie Tooth Disease, Regeneral Complex Pain Syndrome(AKA RSD).

HEENT:

Head	Ears	Eyes	Nose	Throat
Seizures	Hearing Loss	Diabetic Retinopathy	Sinus	Barret
Vertigo		Glaucoma		
		Cataracts		

CARDIOVASCULAR- Hypertension/Hypotension, Congestive Heart Failure, Pace Maker, Heart/Carotid or Arterial, Coronary Artery Disease (CAD),Atrial Fibulation, Peripheral Artery Disease (PAD), Raynaud's

PULMONARY- Asthma, COPD, Emphysema, Lung Cancer,CHF
GI- Reflux, GI Bleeding, Stomach Ulcers, Colon Cancer, Dietary Restriction

REPRODUCTIVE- Ovarian Cysts/Vaginal Cancer, Breast Cancer, Prostrate Cancer,(Radiation and Chemotherapy), Amenorrhea

HEPATIC- Anemia, Sickle Cell Anemia,Hemophilia

ENDOCRIN- Hypothyroidism, Hyperthyroidism, Diabetes, Hyperlipidemia

NEPHROTIC- Kidney Cancer, Reduced Kidney Function,Cyst,Tuberculosis

INFECTIONS- AIDS/HIV, Hepatitis

MENTAL HEALTH- Depression, Bipolar, Postpartum, Alzheimer's, Dementia, Schizophrenia, Siezure Disorders
INTERGLUM (skin)- Basil Cell, Melanoma, Squamous Cell, Hypo pigmented Vitaligo, Xerosis, Dermatitis

MUSCULAR SKELETAL:
ARTHRITIS- Rheumatoid/Osteoarthritis/Bariatric/Gouty/Pseudo Gouty/Post Traumatic Ankylosis Spondylitis, Degenerative Joint Disease/ Fibromyalgia
NECK/BACK PAIN- Stiff, Sore/ Arthrotic, Disc Herniation Sciatica, Radiculopathy/ Peripheral Neuropathy
SHOULDERS- Rotator Cuff, Carpal Tunnel/Arms
HIPS/KNEE- Arthroscopic/ Artificial
LEGS/FEET- Cramps/Tired/ Swelling/Numbness-Fungal ToeNails
GASTROINTESTINAL- Reflux-Ulcer

SIGNATURE:______________________________

SHOES/ORTHOTICS/MISC.

What size shoes do you wear? ____________________
Do you wear orthotics? Yes/No If yes, are they for sports or dress (please circle)?
How old are your orthotics?___________
Who made your last pair of orthotics?______________________________________
Do you go barefoot at home? Yes/No
If yes, what type of floors do you have in your home?____________________________
Do you sit at work or are you on your feet?____________________________________
Do you Exercise?______________How Often?________________________________

AUTHORIZED PERSONS/EMERGENCY CONTACT

Please list the complete names of people and their relationship to you, that you authorize this office to discuss your diagnosis and treatment:____________________________________
____
Emergency Contact Name and Phone #:_____________________________________
Son/Daughter/Wife/Husband/Mother/Father/In-law/Other

_____________________ _____________________________ _____
PRINT PATIENT'S NAME **SIGNATURE-PARENT /GUARGIAN** **DATE**
Or **LEGAL CAREGIVER**

OFFICE POLICIES

Thank you for choosing James M. McKee, DPM, Podiatry Group of Annapolis, PA and Podiatry Group of Annapolis Ambulatory Surgical Center, LLC (collectively “Podiatry Group”) to provide you with foot/ankle care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive and the following are policies of this office which you agree to follow:

APPOINTMENTS
Patients are seen by the order of appointment time, not by arrival time. Any patients who arrive for their scheduled appointments **15 minutes** late will be asked to reschedule their appointment. Our goal is to provide the best care possible to all our patients. It is unfair to patients who arrive timely to have to wait due to the tardiness of others. We appreciate your respect in regards to this policy.

CANCELLATION POLICY
This office requires a **24 hour advance** cancellation notice. If an appointment is missed without **24 hour notice**, the patient shall be responsible for a **$40.00** fee.

INSURANCE
We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

COPAYMENTS AND DEDUCTIBLES
All **copayments, deductibles** and **outstanding** balances, **MUST BE PAID AT TIME OF CHECK IN.** This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

REFERRALS/AUTHORIZATIONS
If your managed care insurance plan requires a referral, it is your responsibility to obtain the appropriate referral **PRIOR** to your appointment. If you do not have a valid, current referral, you will be asked to reschedule your appointment or you will be financially responsible for all services received due in full upon completion of the visit. Back dated referrals will not be accepted.

SIGNATURE____

OFFICE POLICIES CONTINUED

NON-COVERED SERVICES
Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

SELF PAY
Payment in full is due at the time of service If you do not have health insurance OR we do not participate with your healthplan. We can provide a copy of the claim for your own submission.

MEDICARE
We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service. Remember medicare may allow a service and your secondary may not. You will be responsible for that portion.

SECONDARY INSURANCE
We accept secondary insurance **ONLY** when Medicare is the primary or secondary insurer. Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company. **We do not bill secondary insurance if you have a private insurance company as a secondary.**

MEDICARE REQUIREMENT – "AT RISK" / ROUTINE FOOT CARE
If you are insured by Medicare and you are here to obtain "**At Risk" / Routine Foot Care** and you qualify for such care, you shall provide to our office today and on an ongoing subsequent basis the **last date you saw your primary care physician**. If you have not seen your primary care physician within the last **6 months prior** to this appointment and on your subsequent appointments with our office. Medicare will not pay for your visit. If you do not provide us with this date, you will be asked to sign a form called an Advance Beneficiary Notice prior to your care and you will be responsible for payment in full for your visit at that time.

CLAIM SUBMISSION
As an accommodation, we shall submit your claims to your insurance company. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility **whether or not** your insurance company pays your claim. Your insurance policy is a contract between you and your company. If your insurance company does not pay our practice within **90 days** after submitting your claim, **you** will be responsible for any unpaid balance.

SIGNATURE____________________________________

OFFICE POLICIES CONTINUED

RECORD REQUESTS
In order to obtain a copy of your medical records, a written request will need to be executed by you prior to copies being made. In accordance with the federal Privacy Rule 164.524, Podiatry Group has up to 30 days to comply with your request. A fee of $.73 per page will be collected before the documents are prepared. (No documents will be processed before 7 hours after time of request and payment). A fee for mailing will also be collected.

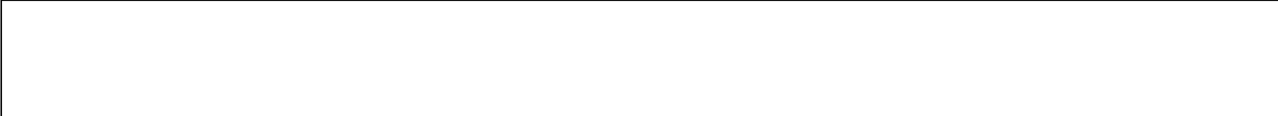
RETURNED CHECK FEE
You agree to pay $45.00 for each personal check returned for non-payment.

MINORS
The responsibility for payment of services rendered to any child/minor whose parents are divorced rests with the parent seeking treatment. Any court ordered responsibility judgment must be determined between the parents involved without the inclusion of our office.

PATIENT BILLING
We accept cash, check or Visa/Mastercard. Any credit balances on a patient's account will be applied to any unpaid balances. If you have not met your deductible at the time of your visit to our office, this office will request payment for services rendered at the time of your visit. If your deductible has been met, an initial invoice shall be generated after payment and/or explanation of benefits (EOB) is received from your insurance company/companies and a balance is due. **Any subsequent invoices shall contain a $5.00 re-processing fee that will be added to your unpaid balance.** If after 60 days from the date of your initial invoice your account is unpaid, this office may forward your account o collections. All fees including, but not limited to a $100.00 collection fee, 15% attorney fee and court costs shall become your responsibility in addition to the balance due to this office. In addition, all unpaid balances 91 days past due will incur interest of 1.5% per month for a corresponding annual percentage rate of 18%, which will be applied from day 31 from the date of the initial invoice until the balance is paid in full. Thank you for understanding our billing policy.

I agree to and acknowledge all the information, disclosures, terms and conditions of our office policies contained on pages 1- 10 of this Patient Registration Form.

______________________	____________________________	_____
Print Patient's Name	**Signature –Patient**	**Date**



PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

________________________ ____________ ________________________

Name of Patient **Date of Birth** **Signature of Patient/Parent/Guardian**
Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:__________________________Last four digits of his/her SSN (required):__________

Print Name:__________________________Last four digits of his/her SSN (required):__________

Print Name:__________________________Last four digits of his/her SSN (required):__________

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number: **Written Communication Address:**

_____________________ _____________________________

____ OK to leave message with detailed information

_____ Leave message with call back numbers only

____ OK to mail to address listed above

____ E-mail me at:________________

Work Telephone Number: ______________________ **Fax Communication:** ______________________

____ OK to leave message with detailed information

____ OK to Fax at the number listed above

____ Leave message with call back numbers only

E-mail me at:______________________________

Other:____

IV. The following person(s) <u>are not authorized</u> to receive my Patient Health Information (PHI):

Print Name:______________________________ **Print Name:**_______________

Print Name:______________________________ **Print Name:**_______________

V. The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

Date of disclosure request	Disclosed to whom: address/fax	Description of disclosure	Purpose of disclosure	Dates of Service of disclosure	Person completing request	Date completed

1. The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive health care at the Practice.

2. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.

6. This authorization is valid as of the date I have signed below and shall remain valid until revoked.

______________________________ ______________________________

Name of Patient (Printed) Signature of Patient Date

FOR OFFICE USE ONLY